MT. SAC
Mt. San Antonio College
Safety & Risk Management

INJURY/INCIDENT WITNESS STATEMENT

Instructions: This form should be completed by the witness to an incident that results in injury or illness. Once complete please return this form to the Risk Management Department in Building 4 Room 2555

Incident Witness Statement **Page 1 of 1**

To be completed by incident witness

Injured employee First Name		Injured employee Last Name			
Witness First Name		Witness Last Name			
Witness Home address:				Tel #	
City		State		Zip Code	
Witness Job Title			Witness Department		
Witness Supervisor Name				Supervisor Tel #	

Employment Type	Employment Category	Length of Employment
❑ Faculty ❑ Staff ❑ Student ❑ Contractor ❑ Others__________	❑ Regular full time ❑ Regular part time ❑ Seasonal ❑ Temporary	❑ 1-6 mos. ❑ 6 mos. – 1 yr. ❑ 1 yr. – 5 yrs. ❑ 5 yrs. (or more)

Describe the incident

Date of Incident		Time of the incident		Shift	❑ 1st ❑ 2nd ❑ 3rd
Location of the Incident (Address)		Specific Location of the incident (e.g office, mechanical room, shop)			
Did the incident involve property damage?	❑ Yes ❑ No	Was a motor vehicle involved in this incident?			❑ Yes ❑ No

Affected body Part:

❑ Head/face ❑ Eye ❑ Neck/shoulder ❑ Arms/elbow ❑ Right Hand ❑ Left Hand ❑ Wrist/Head ❑ Rib
❑ Fingers ❑ Chest/lower trunk ❑ Hip ❑ Back ❑ Leg/knee ❑ Foot/ankle ❑ Toes
❑ Other _________

Describe, step-by-step, how the incident occurred:

Witness Signature		Date	